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ABSTRACT

This report discusses the need for program accreditation and licensure in allied health fields, and in particular, addresses two issues: (1) an attempt by the American Physical Therapy Association to increase the entry-level standards for physical therapy education without achieving consensus; and (2) the attempt to reduce entry-level standards for dental hygienists by sources outside the profession, again with no attempt to achieve consensus. It is noted that the system of educational program accreditation and occupational licensure have had two very important results: (1) by maintaining a nationwide standard of quality it enables Americans to move more confidently from state to state; and (2) it provides career mobility for health professionals, who by meeting the established standards may practice almost anywhere in the United States. Among the report's comments are that any proposal for substantive change in health professions education that is not based on collaboration and consensus would be a step backward in terms of quality assurance, and that, although it may be appropriate to periodically reassess entry-level standards in individual health care fields, such a reassessment must be done on a collaborative basis, not by the profession or any other interest group acting alone. The report concludes that the proposed changes in physical therapy and dental hygienist entry-level standards have not been justified by careful evaluation and are not supported by broad-based consensus. (GLR)

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THE IMPORTANCE OF CONSENSUS IN DETERMINING EDUCATIONAL STANDARDS IN HEALTH AND HUMAN SERVICES FIELDS

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The SREB Health and Human Services Advisory Commission recommends that no significant changes should be made in the basic standards of education for any health occupation unless and until clear justification has been established. Acceptable justification must be based on comprehensive evaluation of the knowledge and skills required for practitioners in the field to meet broadly recognized minimum standards of quality. The Commission's recommendation applies to any changes that would substantially increase or decrease the entry-level requirements in a field.

- Recent controversies in the fields of ***dental hygiene*** and ***physical therapy*** threaten the credibility of the United States system of program accreditation and licensure for the health professions.
- This system assures that health professionals meet comparable ***minimum educational standards*** nationwide.
- The system is based on achieving ***consensus*** among each profession and the community of interest in that field.
- Proposals to ***reduce*** entry-level standards in dental hygiene and to ***increase*** entry-level standards in physical therapy have not been justified by careful evaluation and are not supported by broad-based consensus.
- Proposals to reintroduce ***preceptorship*** training in dental hygiene, abandoned as inadequate more than 20 years ago in all but a single state, threaten both the quality of patient care and the career mobility of hygienists.
- It may be appropriate periodically to ***reassess*** entry-level standards in individual health care fields, but such a reassessment must be done on a collaborative basis, not by the profession or any other interest group acting alone.
- Any proposal for substantive change in health professions education that is not based on ***collaboration and consensus*** would be a step backward in terms of quality assurance.

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Background

In no area of endeavor are educational standards and scope of professional practice more closely regulated than in health care. Through the dual methods of program accreditation and occupational licensure, it is possible (with a few singular exceptions) to make basic assumptions about the qualifications of key members of the health care team, regardless of where in the United States they may be working.

The modern system of licensure and accreditation in the United States has evolved over eight decades. The publication in 1910 of Abraham Flexner's landmark report, *Medical Education in the United States and Canada,* was the watershed in regulating qualifications of health care professionals. The Flexner report, which was sponsored by the Carnegie Foundation for Excellence in Teaching, forced dozens of poor quality medical schools to close and led to the framework for standardized professional education that prevails today. Whether this framework is the only workable approach can be debated. There can be little argument, however, that it does assure that programs training physicians and other health professionals meet specified minimum standards for curriculum and quality of instruction.

Each of the nation's major health professions follows the model of educational program accreditation and occupational licensure first established by medicine. Dentistry, optometry, osteopathic medicine, pharmacy, podiatry, registered nursing, and veterinary medicine all accredit programs through a process involving semi-autonomous accrediting bodies that typically include educators and practitioners in the field as well as representatives of related disciplines and the public. Every state requires that members of these professions be licensed in order to practice and, in every case, eligibility for licensure is restricted to graduates of programs that are either accredited or otherwise determined to meet minimum educational standards.

Among allied health professions the situation has been much the same. The principal difference has been that many of the allied health professions have emerged relatively recently. In many cases, the older, well established professions have actively encouraged and assisted the process of accreditation for allied health programs. Thus, the American Medical Association sponsors the Committee on Allied Health Education and Accreditation (CAHEA). In collaboration with professional organizations in each field, CAHEA sets standards for and accredits educational programs in more than two dozen allied health fields, including medical technology, occupational therapy, radiography, and respiratory therapy. Similarly, the American Dental Association plays an important role in accrediting programs in dental hygiene, dental laboratory technology, and dental assisting. The American Optometric Association, American Pharmaceutical Association, and American Veterinary Medical Association are also involved in accrediting programs in related allied health fields. Several other allied health professions, including physical therapy, dietetics, and speech pathology and audiology, accredit educational programs independently.

As a general rule, the importance of program accreditation and the extent of licensure in allied health fields are related to the amount of direct patient care provided. While many allied health professions are licensed in one or more states, only two--*dental hygiene* and *physical therapy*--are licensed by every state. Not surprisingly, these are also the two allied health fields in which program accreditation plays the most important role. Graduation from an accredited educational program is a requirement for dental hygiene or physical therapy licensure in most states, and non-accredited programs are virtually unknown in these two fields. In fields where licensure is less widespread, non-accredited programs are commonplace.

The one feature common to virtually all accredited health occupations is that program standards have been developed over time through a consensus process. To be meaningful, accreditation must reflect collaboration between the accredited profession and the community of interest affected by the profession. The needs and concerns of potential employers, federal and state regulatory agencies, and other closely related professions must be weighed and balanced. Ultimately, there must be consensus among all of these parties that the standards developed are reasonable and in the public interest. In such a process it is inevitable that some will be dissatisfied with the results. Where broad consensus has been achieved, however, the interests of all parties will be well served.

In disciplines where entry into practice is restricted by state licensure requirements, and especially where eligibility for licensure is tied to completion of an accredited program, the importance of achieving and maintaining consensus in both processes is critical. The concept of professional licensure itself is based in part on the assumption that consensus can be achieved regarding minimum standards of education and training in any given field.

Physical Therapy

The 1980s were an exciting time for physical therapy. Changes in federal Medicare reimbursement policies early in the decade made independent practice a realistic career option. As the responsibilities of physical therapists expanded, income levels rose and student interest in the field grew. Increased autonomy placed added demands on physical therapy education, and the entry-level curriculum grew longer. Today, it is not unusual for it to take five years to complete a baccalaureate physical therapy program. Finally, the American Physical Therapy Association (APTA) responded to the extension of the curriculum by seeking to make the master's rather than the baccalaureate degree the entry-level credential.

The question of whether changes in physical therapy education and practice justify increasing the entry level has been debated extensively and inconclusively. There will be no attempt here to continue that debate. A more important issue raised by the controversy involves the relationship between accreditation and licensure.

All states require that physical therapists be licensed, and most tie eligibility for licensure to graduation from an accredited program. Acting as the accrediting body, the APTA sought to raise the entry level into the field by changing program standards so that only master's degree programs would be eligible for accreditation. Because of the link between licensure and accreditation in most states, this change in accreditation requirements would have forced virtually all states and all educational institutions to accept APTA's decision.

The APTA action resulted in a storm of protest from higher education officials nationwide. Much of this protest took the form of arguments about the merits of the entry-level master's. However, it is doubtful that this topic would have generated such controversy had the APTA not sought to use the accreditation process to achieve a goal that was widely viewed as being of primary benefit to the profession itself. Moreover, it had done so without first seeking to build a broad base of support. Physical therapists argue that there is consensus *within* the profession on the need for an entry-level master's. However, by moving forward without first achieving consensus among the broader community of interest, the APTA virtually assured widespread opposition to its goal.

In response to the APTA action, legislation was proposed in a number of states to weaken or eliminate entirely the requirement that physical therapists must be graduates of accredited programs to be eligible for licensure. Faced with the threat of wholesale changes in licensure laws that would, in effect, have invalidated the existing accreditation process, the APTA ultimately backed off from its proposal to change the entry level. APTA also took steps to demonstrate that its accreditation process operates independently. Much damage had already been done to the credibility of that accreditation process, however, and the questions this incident raised about the credibility of specialized accreditation in general will undoubtedly have long-term implications.

In the wake of the physical therapy controversy, legislators and higher education officials have become increasingly skeptical about the objectivity and usefulness of specialized program accreditation. Some questioning of certain accreditation guidelines and procedures is probably appropriate. On the other hand, the current system of assuring comparable quality among educational programs in the same field has been extremely valuable to both consumers and students. Weakening that system by short-sighted and self-serving misuse of the accreditation process would leave a void that could not easily be filled.

Dental Hygiene

The situation facing dental hygiene is, in many ways, the opposite of that in physical therapy. Yet, its implications for the system of program accreditation and licensure are equally profound. In physical therapy, the profession attempted to increase its entry-level standards unilaterally without first achieving consensus.

In dental hygiene, efforts to *reduce* entry-level standards unilaterally are coming from sources outside the profession itself, but again with no attempt to achieve consensus.

Unlike physical therapy, where the accreditation process functions independently of those for any other occupation, programs in dental hygiene are accredited by the Commission on Dental Accreditation of the American Dental Association. The earliest accreditation standards for dental hygiene were developed in the late 1940s by the combined efforts of four groups--the American Dental Association's Council on Dental Education, the American Association of Dental Examiners, the American Association of Dental Schools, and the American Dental Hygienists' Association. The standards have been revised several times in the ensuing years, always after careful study.

The earliest dental hygiene programs in the United States were all academic programs developed by educational institutions. In most areas of the country, the academic model was the only one ever seriously considered. In a number of Southern states, however, dental hygienists, at one time, could also be trained by individual dentists acting as preceptors. By the mid-1960s, it had become clear that preceptorship was inadequate to prepare hygienists for their important role in providing direct patient care. The move away from preceptorship training in favor of academic programs in the region reflected a broad consensus among dentists, dental hygienists, and others affected by dental hygiene education and practice. State dental associations were often in the forefront of efforts to upgrade dental hygiene education.

Today, to be eligible for accreditation, an entry-level dental hygiene program *must* be offered by an accredited institution of higher education and include at least two academic years of full-time study or its equivalent. Programs must award an associate or baccalaureate degree or a comparable credential, such as a certificate. In all institutions, the curriculum must be at the college level and prepare students to continue their education if they so desire.

As noted earlier, dental hygiene is one of only two allied health professions licensed in every state. In 49 of those states, graduation from an accredited dental hygiene program is a prerequisite for licensure. All programs in those 49 states either are accredited or are candidates for accreditation. In 47 states, hygienists are also required to pass the *National Board Dental Hygiene Examination*.

The one state that does not tie licensure to accreditation is Alabama. Alone among the 50 states, Alabama has retained a system of non-academic preceptorship training called the "Alabama Dental Hygiene Program." Under this system, licensed dentists are approved by the state dental licensing board to provide on-the-job training in dental hygiene to dental assistants. (Dental assistants are not licensed in any state.) Upon completing this training, plus 165 classroom hours of basic sciences and clinical instruction, these students are eligible for licensure as dental hygienists in Alabama. (Accredited programs generally include a minimum of approximately 1,000 classroom hours.) These preceptor-trained hygienists cannot be licensed in any other state, are not eligible to take the National Board Dental Hygiene Examination, and their training cannot be applied toward any type of college degree.

Alabama also has one fully accredited dental hygiene program, at the University of Alabama at Birmingham. As is true for graduates of all dental hygiene programs in the other 49 states, graduates of the University of Alabama program are eligible for licensure in all 50 states.

Since the mid 1980s, representatives of organized dentistry in a number of states across the country have made a variety of attempts to diminish the status of dental hygiene. In some cases, this has involved changing the state regulations that govern dental hygiene practice either to increase the requirements for supervision by a dentist or to limit the type and number of functions a hygienist legally may perform.

Recently, these efforts have taken a new direction. State dental associations in a number of states have advocated changes that would permit licensure of hygienists trained by non-academic preceptorship programs similar to those in Alabama. Legislation of this type has been introduced in both Georgia and Tennessee. Although none of these bills have yet become law, it is likely that similar legislation may be reintroduced in future sessions.

In Florida, the state dental association has taken a somewhat different approach. At the urging of the dental association, the state's dental licensure board adopted a rule change in 1989 that would allow Alabama preceptorship graduates to take the Florida dental hygiene licensure examination. This rule currently is being appealed by the state dental hygienists' association. (Dental hygienists have only token representation, and in some cases none at all, on most of the state dental boards that control their licensure.) In any case, the rule change is unlikely to have an immediate impact, since Florida also requires hygienists to pass the National Board Dental Hygiene Examination and, as noted previously, Alabama preceptorship graduates are not eligible to take that exam. This would render the rule change moot unless the Florida board either acts to eliminate the national exam as a requirement for licensure or persuades the National Board to ease its requirements for taking the exam.

Advocates of lowering the educational requirements for dental hygienists have argued that the changes are needed to alleviate shortages of hygienists. There is little evidence, however, that any such shortages exist. In both Florida and Georgia, for example, the ratios of active dental hygienists to active dentists are far higher than the average for the United States as a whole. It should also be noted that neither Florida, Georgia, nor Tennessee offers any type of reciprocity or licensure by credentials to graduates of fully accredited dental hygiene programs who are licensed in other states. Amid the proposals to reduce educational requirements for hygienists, there has been no suggestion that reciprocity might help alleviate the supposed shortages.

Dental hygienists are direct patient care providers whose work has an immediate impact on the physical well-being of patients. With their emphasis on preventive services, hygienists have played an important role in achieving dramatic reductions in dental disease in the United States. Those improvements in the nation's oral health and resulting changes in the need for dental services may well have implications not

only for dental hygiene education but for dental education as well. However, efforts by certain segments of organized dentistry, in conjunction with supposedly independent state licensure boards, to unilaterally impose dramatic reductions in educational standards for dental hygienists are clearly at odds with the public interest.

As in the case of physical therapy, the issue of most concern is not the pros or cons of a particular approach to dental hygiene education but, rather, the manner in which standards for professional education are determined. National educational standards for dental hygiene, and for all other health professions, have evolved through careful deliberation over a period of many years. Organized dentistry was an important player in achieving the consensus that *eliminated* preceptorship everywhere but in Alabama. Dental hygienists and dental hygiene educators have been virtually unanimous in their opposition to the proposed resurrection of preceptorship. Many dentists and dental educators have opposed the changes as well, so there can be no question of any consensus having been reached. In fact, a major article in a recent issue of the *Journal of Dental Education* (March 1990) proposes a *baccalaureate* curriculum as the *minimum* entry level needed for dental hygiene in the future.

Perhaps the most troubling aspect of the current controversy is that it represents a denial by a significant segment of the dental profession of the validity of a consensus-based system of accreditation and licensure. Ironically, dentistry was instrumental in developing that system. As such, it not only brings into question the validity of the accreditation process for dental hygiene programs, but those for all other fields accredited through the same process as well, including dental education itself.

Conclusion

The combination of educational program accreditation and occupational licensure has been extremely important to the system of health care in the United States. By ensuring that educational programs meet minimal standards, and by making completion of such a program an important criterion in determining an individual's eligibility for licensure, the system accomplishes two very important results: (1) It makes it possible for Americans to move from state to state with confidence that, when health care is needed, the professionals who provide that care will have met the same minimum standards. (2) It also provides an important level of career mobility for health professionals--the ability to practice one's chosen profession *almost* anywhere in the country.

These advantages have not been achieved universally. Many dental hygienists practicing today in Alabama have not met the minimum educational standards required for licensure in the rest of the country. For those hygienists who complete the Alabama preceptorship program, a move to another state would force abandonment of their chosen field unless they were willing and able to commit a minimum of two years in an accredited academic program. The proposed reductions in licensure requirements in Florida, Georgia, and Tennessee might expand job mobility for *Alabama* preceptorship graduates. However, they would also mean that individuals

seeking dental hygiene services in those three states would, like residents of Alabama, be faced with uncertainty about the qualifications of the hygienists who provide those services. Such a situation could only be regarded as a serious step backward--away from a system of quality assurance in health professions education that has taken eight decades to develop.

The situation in physical therapy is no less troubling. The furor created by the American Physical Therapy Association's attempt to force an increase in the entry-level standards has so polarized opinion that it is doubtful whether any reasoned dialogue on this issue will be possible in the near future. At a time when physical therapy is playing an increasingly important role in the health care system, the public interest is not well served in a debate shaped by animosity over procedural issues rather than substantive evaluation of educational requirements.

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